This form may be completed online, printed and mailed to the address listed below.

ATTACHMENT G

STATE OF NEBRASKA
Department of Health and Human Services
REGULATION AND LICENSURE – Credentialing Division
PO Box 94986 – Lincoln, NE 68509-4986
Telephone #: (402) 471-2117

APPLICATION FOR LICENSURE AS A NURSING HOME ADMINISTRATOR OF A FACILITY CARING PRIMARILY FOR PERSONS WITH HEAD INJURIES AND ASSOCIATED DISORDERS

SECTION A – PERSONAL INFORMATION				
1	Name	First:	Middle:	Last:
2	Address:	Street/PO/Route:		
		City:	State:	Zip:
3	Telephone Number (Optional)			
4	Social Security Number			
5	Date of Birth:		Place of Birth:	
	➔ **Attach** a photocopy of your birth certificate or equivalent documentation.			

SECTION B – MORAL CHARACTER			
1	Have you ever been convicted of a misdemeanor or a felony?	Yes ❒	No ❒
	If yes, state what crime, date of conviction, name, location of court (City, County, State)		
	Crime / Date of Conviction / Name/Location of Court		
2	Are you licensed or certified in another state:	Yes ❒	No ❒
	If yes, list the profession and State of Licensure:		
3	Has disciplinary action been taken against your license in the other state?	Yes ❒	No ❒
	If yes, state date & type of action, name & address of entity taking such action:		
	Type of Action / Date of Action / Name/Address of Entity taking Action		
4	Have you ever been denied licensure or been refused renewal?	Yes ❒	No ❒
	If yes, state date & type of action, name & address of entity taking such action:		
	Type of Action / Date of Action / Name/Address of Entity taking Action		
	➔ **IF CONVICTED, SUBMIT** official court records which indicate, the circumstances and nature of the conviction, the date of the conviction, the name and location of court where the conviction was issued, the conditions and current disposition of probation, if applicable, treatment records, and other similar documentation which would provide a thorough evaluation of the conviction circumstances or may be requested by the Board		

SECTION C – LICENSE FEES

Determine the month and year in which you are submitting your application. If the month falls in the shaded area of the following chart, the fee for initial licensure is **$62.00**. If the month falls in the unshaded area, the fee for initial licensure is **$61.00** or **$26.00** dollars if your license is issued within 180 days of the renewal**.**

YEAR	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Even	$61	$61	$61	$61	$61	$61	$26	$26	$26	$26	$26	$26
Odd	$62	$62	$62	$62	$62	$62	$62	$62	$62	$62	$62	$62

Make payable to: CREDENTIALING DIVISION

NOTE: Licenses expire December 31st of even numbered years

www.hhs.state.ne.us/crl/mhcs/nha/headapp.pdf

SECTION D – LICENSURE APPLICATION CATEGORY – (All applicants must complete this section) Check the appropriate process by which you are applying for licensure	
❒	Psychologist with at least a master's degree in psychology from an accredited college or university with:
	❒ Specialized training
	OR
	❒ One or more years of experience working with persons with traumatic head injury or severe physical disability
❒	Physician licensed under the Uniform Licensing Law to practice Medicine and Surgery with:
	❒ Specialized training
	OR
	❒ One or more years of experience working with persons with traumatic head injury or severe physical disability
❒	Certified Social Worker under the Uniform Licensing Law with three (3) years of experience in social work and:
	❒ specialized training
	OR
	❒ one or more years of experience working with persons with traumatic head injury or severe physical disability.
❒	Certified Master Social Worker under the Uniform Licensing Law with three (3) years of experience in social work and:
	❒ specialized training
	OR
	❒ one or more years of experience working with persons with traumatic head injury or severe physical disability.
❒	Licensed Mental Health Practitioner under the Uniform Licensing Law with three years of experience in mental health and:
	☐ specialized training
	OR
	☐ one or more years of experience working with persons with traumatic head injury or severe physical disability.

SECTION E – EDUCATION: All applicants must complete this section and submit or cause to be submitted an Official Certified Transcript (If more space is needed, use an additional sheet)					
❒	Transcript Attached	❒	Forwarded Separately	❒	Previously Submitted
Institution Name:					
Address:	Street/PO/Route:				
	City:		State:		Zip:
M/D/Y of Graduation		Degree:			
Major:					

SECTION F – TRAINING OR EXPERIENCE: (All applicants applying must have at least one year of specialized training OR one year of experience working with persons with head injuries or severe physical disabilities; and at least one year of experience in an administrative capacity)

1	Briefly describe the experience you have spent in an administrative capacity:			
	Name of facility or institution in which you completed such experience:			
	Address:	Street/PO/Route:		
		City:	State:	Zip:
	Duration of Experience:	From (M/D/Y)	To (M/D/Y)	
2	Briefly describe the specialized training you have received:			
	Name of facility or institution in which you completed such experience:			
	Address:	Street/PO/Route:		
		City:	State:	Zip:
	Duration of Experience:	From (M/D/Y)	To (M/D/Y)	
3	Briefly describe the experience you have received working with persons with head injuries or severe physical disabilities:			
	Name of facility or institution in which you completed such experience:			
	Address:	Street/PO/Route:		
		City:	State:	Zip:
	Duration of Experience:	From (M/D/Y)	To (M/D/Y)	

SECTION H – ATTESTATION (All applicants must complete this section)

I hereby state that I am the person making application, I am of good moral character, and the statements on this application are true and complete. I further state that:

❑ I have not practiced in Nebraska without a nursing home administrator credential prior to this application for licensure;

❑ I have practiced in Nebraska without a nursing home administrator credential prior to this application for licensure (does not include the time you may have held a provisional, mentoring registration or administrator-in-training registration).

____ number of days in Nebraska prior to July 1, 2004

____ number of days in Nebraska after July 1, 2004

_____
(Signature of Applicant)

_____ date